STANFORD UNIVERSITY MEDICAL CENTER
STANFORD, CALIFORNIA 94305 • (415) 321-1200

STANFORD UNIVERSITY SCHOOL OF MEDICINE
Department of Surgery

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Arthur Kornberg, M.D.
Department of Biochemistry
Stanford University

Dear Arthur:

Enclosed are two corrected copies of the abstract that I am submitting for consideration for the program of the Western Surgical Association. Actually, while the data from the East Bay are elegant, I do not need to cite them in view of the other evidence presented.

As I said to you a minute ago on the phone, I would like to detail the full scope of the problem in as brief a manner as I can. It will still be long!

First, about my own data -- these were as accurately collected, and the statistical scaffold as carefully planned, as it was possible to do in a large human study. Because we knew the origin of every donor, it was possible to establish that our prison donors created hepatitis in our patients eleven times more commonly than when volunteer donors were used. This we published in considerable detail over a period of several years, beginning in 1959, and continuing, with major emphasis on commercialism, in 1962, 1964, 1966 and yearly thereafter, each paper being a new and separate facet of the central theme. No one has yet presented data with at least 98% follow-up until death or 180 days, whichever came first.

I could not possibly justify publishing our basic data except that it represents a 12-year prospective study at a time when little was known about hepatitis and, therefore, little was done to screen donors who might transmit it. It represents hepatitis "in the raw", and this situation will not again occur. I regret that it is the only study ever made in a large general hospital, in a prospective fashion, on this subject. People in the field, especially CDC and the State Health Departments, have been asking me for these basic data for ten Years.

There are several facets to the problem of establishing an excellent national all-volunteer blood program, and there are a number of conflicts of interest that one soon runs abruptly into. I have explored every channel that I have encountered.

First, blood insurance programs are detrimental to an all-volunteer blood program because their operation means that the insurance

company pays the hospital, the hospital pays the blood bank and the blood bank buys 2 to 4 units of commercial blood for the amount the insurance company has paid for one unit (see collage of clippings). I have dealt with Mr. Orsini, Director of the Health Insurance Association of America, 750 Third Ave., New York City. His association covers 76 million of our population. His response, of a year ago, was to the effect that if his commercial insurance companies didn't cover blood, Blood Services of Arizona would. He was quite correct, as this Arizona organization is nearly nation-wide, listed as non-profit, and has also its own blood insurance program.

I have taken this subject up also with Mr. Walter J. McNerney, President of Blue Cross Association, 840 North Lakeshore Drive, Chicago. Blue Cross insures 70 million people, but only a few of their policies pay for blood. Medicare represents another form of insurance covered by Blue Cross, as Director Ball of the Social Security Administration in Washington has written to me. They cover about 20 million of our population for blood. Any blood from Blue Cross and Medicare is commercial.

The Veterans Administration is still another. Their book-keeping activities for blood are in Chicago. They claim that about one half of their blood is provided by Red Cross and the rest is from commercial sources.

Secondly, I have written to the major medical organizations, such as to Dr. Edwin Crosby, Director of the American Hospital Association, also at 840 North Lakeshore Drive, Chicago. They are unresponsive. To my surprise, after no progress over the past several years, I have finally gotten a resolution through the A.M.A. House of Delegates, which reads that the patient's physician should be informed as to the source of blood before it is given as a transfusion. (Dick Wilbur helped me here). The American College of Surgeons has been unresponsive. The American Association of Blood Banks has been very actively hostile.

The only common denominator in the difficulties I have encountered has to do with money. The profits are enormous in both insurance and blood banking, even when they are listed as not-for-profit. The hospital also makes a good deal of money, as the enclosed table indicates.

Third, in government and the National Research Council, it has been particularly difficult to get a fair hearing. The Division of Biologics Standards has been opposed to even the simple act of labeling bloods as either donated, paid or from prisons. (The latter two carry identical hazards). The only rationale I can conceive for their position is that they are unwilling to recognize that there are two kinds of donor populations, relatively safe and very hazardous. If D.B.S. itself admitted this discrepancy, we would be forced into an all-volunteer program. One can ask why they are unwilling to face these facts. First, the lobby for blood banks is quite substantial. Also, one director and one associated director of D.B.S., are now highly paid employees of Blood Services of Arizona, and at least one

more individual from D.B.S. is with Hyland Laboratories commercial blood bank in Los Angeles. This constitutes no conclusive evidence, but neither is it a pleasant fact to note.

The most important single obstruction that I have encountered with D.B.S. came up over an article written by Cohen and Daughtery, of the New Jersey State Health Department, and published in the JAMA of February 5, 1968. Theirs was a very special situation, but it did constitute an excellent study. One donor population was thought to be composed largely, if not totally, of drug addicts. A similar and matched population of volunteer donors from the same area were studied at the same time. Seventy times as many cases of hepatitis resulted from the addict group. This time I wrote to Dr. Goddard, then head of FDA, because I had gotten nowhere with D.B.S or the N.R.C. Dr. Goddard wrote me by return mail that he was forwarding the article and my note to D.B.S., who once again sat on it -- this time for three months. As of fifteen months ago, Dr. Sam Gibson, Associate Director of D.B.S., answered Congressman Diggs from Detroit, who had inquired about the need for legislation, to the effect that "we have no problem, and when we need legislation we will let you know"! Congressman Diggs was good enough to send that letter on to me. It is futile for me to attempt a dialogue any longer with D.B.S. and N.R.C.

Now why has the American National Red Cross not developed a substantial and reliable all-volunteer national blood program? In the first place, when the Red Cross began its present program in 1948, they were competing with many existing private blood banks throughout the country, and have never been able to forge a satisfactory single program. They have fumbled along and, until recently, have drawn rather heavily from prison donor populations. I am informed by President Elsey of the ANRC in Washington that as of July 1, 1971, they are no longer drawing prison blood. The Red Cross probably draws 45-50% of blood in this country. They have 59 drawing stations in 42 states (two in California). Frankly, I think Red Cross should tool up adequately for the whole job, or get out of the field.

A year and a half ago, I decided that publishing papers on more extensive data in scientific journals was not paying off, nor was the correspondence with the various agencies I have mentioned. There were two areas that seemed hopeful. One was the labor unions. I struck a home-run when I wrote to George Meany of the AFL-CIO. He put me in touch with his best man in human relations, and we have worked together on this subject in a number of ways ever since. This man, Leo Perlis, Director of Community Services, asked me to draw up some resolutions of what I thought the AFL-CIO should adopt in their contract dealings. A copy of this is enclosed, and it has proved very useful. In its present style, it is largely the writing of Leo Perlis.

The second area that I turned to was that of the law. Together with Professor Marc Franklin of our Law School, we have attempted to

make hepatitis compensable, if adequate precautions have not been taken. Such a law was successfully passed in Illinois, another in the State of Washington, and most recently in Texas. I was able to have a piece of legislation, AB 2889, withdrawn at the California legislature this spring. It had been promoted by the California Association of Blood Banks. Its purpose was to have blood declared a service and not a product, and therefore avoid the strict tort liability theory. Three years ago, I proposed a law, through Assemblyman Green from San Diego, that prisoners no longer be given five days off for each unit of blood they donated. This passed easily, but I have no idea how well it is enforced because Irwin Memorial Blood Bank of San Francisco still draws some blood from San Quentin. That same year a similar law was passed in Wisconsin.

In this spring's Law Reviews from some 15 to 20 University Law Schools, fairly lengthy articles appeared on this subject. One is supposed to appear in the Stanford Law Review as soon as it is published. About 80% of these articles favor making the doctor and hospital liable for hepatitis if better donor selection is not built into their blood programs.

One man, even with good friends outside the scientific field, cannot do this alone. If the National Academy of Science were to hear these facts, I believe something would change. But it will not change if it is left to the D.B.S. or the N.R.C.

You are welcome to pass this on the David Perlman, because I have made no statement that is not covered by a letter or a document on file in my office.

There is more to the story, but I have tried your patience enough. I think I have done my share for taxpayers, but the government we support has got to come through. I would appreciate your advice.

Sincerely,

J. Garrott Allen, M.D.

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